

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

19468

File No. _____
Registered No. **5058**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **797**
Township _____ Primary Registration District No. **1003**
City **St. Louis, Mo.** (No. **2101 1/2 Walnut**)

2. FULL NAME

Eddie Chandler

(a) Residence, No. **2101 1/2 Walnut** St., **22** Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **1** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Col.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **William Chandler**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Not known**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
about 26		-	-	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Jones ark**

10. NAME OF FATHER

Jacob Randel

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Not known**

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Not known**

14.

INFORMANT

(Address) **William Chandler**
2101 1/2 Walnut St.

15.

FILED **44** - **4** 19**29** **May E. Starckoff**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 3 1929**

17. I HEREBY CERTIFY, That I attended deceased from **March 23** 19**29** to **May 3** 19**29** that I last saw her alive on **May 3** 19**29**, and that death occurred, on the date stated above, at **4:15 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

23A Pulmonary Tuberculosis
(duration) yrs. **3** mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) **W. N. S. Clark** M. D.

5/3 1929 (Address) **1635 Barr St**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Blytheville, Ark.

DATE OF BURIAL

5/5 1929

20. UNDERTAKER

Louise Bros.

ADDRESS

2153 Jeff Ave

WRITE FAIRLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

